

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-001201

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 230

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>SPRINGFIELD</u>		c. CITY OR TOWN <u>SPRINGFIELD</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. JOHN'S HOSP.</u>		d. STREET ADDRESS <u>1226 E. LINWOOD</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>SCHELLHARDT</u> Last <u>SCHELLHARDT</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>10</u> Year <u>1963</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/7/75</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. AGE (last birthday) <u>88</u>
13a. FATHER'S NAME <u>WILLIAM PARKER</u>		13b. MOTHER'S MAIDEN NAME <u>SARAH J. SIMCOX</u>	12. CITIZENSHIP OF WHAT COUNTRY <u>U.S.A.</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of <u>NO</u>)		17. HUSBAND'S NAME (If deceased) <u>HENRY W. (DECEASED)</u>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia, Acute 3 days</u>		19. INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) _____ DUE TO (c) _____		PART III. IF deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. IF deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART II or PART III off item 18b)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <u>Feb 10, 63</u> and last saw <u>Feb 10, 1963</u> alive on <u>Feb 10, 1963</u>		Death occurred at <u>6:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Don J. Silsby M.D.</u>		22b. ADDRESS <u>Springfield, Mo</u>	22c. DATE SIGNED <u>2/12/63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>2/13/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ST. MARY'S CEMETERY</u>	23d. COUNTY (City, town, or county) (State) <u>SPRINGFIELD, MO.</u>
24. FUNERAL DIRECTOR ADDRESS <u>H.H. LOHMEYER FUNERAL HOME</u>		25. DATE RECD. BY LOCAL REG. <u>2-13-63</u>	26. REG. STRA'S SIGNATURE <u>Effie E. Mullen</u>

H.H. LOHMEYER FUNERAL HOME
SPRINGFIELD, MO.

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

Permit 2-10-63

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Thurman T. Shively

Licensed Embalmer No. 4815

P. O. Address Springfield, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.